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·1942·

MARCH 1981 VOL.XXXVII NO. 3

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The official bulletin for The Hampden District of The Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.
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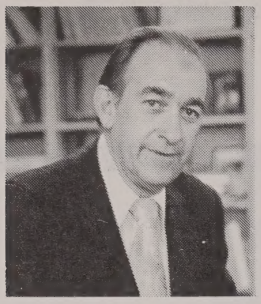

J.J. SIRAGUSA, JR., M.D.
President

PRESIDENT'S PAGE

WHITHER PRSO

When the PRSO was born most of us were disturbed, and rightfully so, by the prospect of the government being involved with the program. We must recognize that one of the reasons that the government gets involved in many programs is because they recognize the need for action in an area that has not been acted upon by the private sector. The best way to keep the government out of any such program is for the private sector to take initiative before the government has the opportunity to mandate it. Such was the case with the PRSO program.

Fortunately, through the efforts of the American Medical Association with the help of Senator Bennett, legislation, was enacted in such a way that the physicians were given charge of the show and the program was set up on a regional basis with reasonably good guarantees of regional autonomy. As always happens, the government gradually became more oppressive and meddlesome with their mandates and transmittals. By rather persistent scuffling on the part of physicians and staff in our program, we have managed to ward off a considerable amount of government interference. At the last meeting of the House of Delegates on the American Medical Association the Delegates voted by a small margin to work for elimination of the enabling Legislation for PRSO. It is interesting to note that the Massachusetts Delegates voted unanimously to preserve the program. I was personnally disturbed by the vote of the Delegates to eliminate the program until I had the opportunity to speak to many of them at the American Medical Association Leadership Conference last month. It was apparent that all of the Delegates recognized the fact that a coordinated regional peer review program is neccessary. What they were voting for was to get the government out of the act. No one in the medical family can really argue with that. It would simply be a matter of getting a similar program privately funded through insurers, private industry, and the provider community.

We must keep in perspective the fact that there is overwhelming evidence that a regionialized peer review program is neccessary. The program as it exists in Western Massachusetts has some very strong plusses. We have maintained a fair degree of regional autonomy and we have also managed to effectively transfer a great amount of autonomy to individual medical staffs through

hospital delegation. Considerable headway is being made in eliminating any kind of peer review efforts by any other agencies, particularly the State, by establishing enough credibility in our program to become the sole peer review mechanism. This is very much to our advantage.

It is important that all of you as individuals realize that the PRSO program continues to need your support and help. We must work together to do a job that needs to be done, with or without the government, and maintain physician control. □

J.J. SIRAGUSA, JR., M.D.
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Cost-Containment Pressures And The Future of PSROs

James Morton
Executive Director
Western Massachusetts Professional Standards Review Organization

In recent months, there has been a flurry of predictions that the PSRO program's days are numbered.

The new President's landslide victory may in large part be attributable to his goal of getting the government off our backs. His new Director of Management and Budget, Mr. Stockman, has called for repeal of the PSRO program. Mr. Schweiker, the new Secretary of Health and Human Services, has questioned the program's cost-effectiveness despite a recent Congressional Budget Office study that it had saved $17 million more in tax dollars than had been spent.

Perhaps equally important, the AMA House of Delegates voted in December to encourage elimination of PSROs. This was a surprise resolution which was introduced at the end of the meeting after many delegates had left and which passed by the narrow margin of 104 to 100. Nevertheless, it has received considerable attention, in part because the AMA has been a strong supporter of PSROs in recent years.

In light of the new administration's philosophy and related statements, do PSROs have a future? I hesitate to make a prediction about future Congressional action. Development of the coalitions necessary for any legislative action is rarely predictable.

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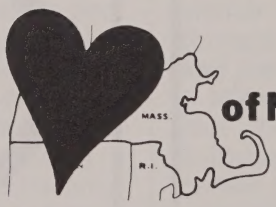
In The Hart  of New England

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However, the overriding pressures to cut taxes and spending have strong implications for the future of the Medicare and MEDICAID PROGRAMS WHOSE BENEFICIARIES ARE SUBJECT TO PSRO reveiw. Many commentators have discerned two alternative and very different basic strategies for slowing the rapid rise in Medicare and Medicaid expenditures. One strategy is rationing. The other is competition. Both are designed to force recognition by patients and physicians or resource constraints.

A rationing strategy was favored by the Carter Administration. Rationing is a ''top-down'' approach, involving the establishment of an overall fixed budget which is then allocated among local jurisdictions. There can be many variations in the rationing strategy. For example, the fixed budget can be denominated in dollars, number of hospital beds, rate of cost increase, or other terms. The defunct hospital cost-containment proposal was a rationing (i.e., fixed-budget) approach. The British National Health Service is also a rigidly-rationed system. In any form, rationing involves politically-motivated, inefficiently-distributed allocations of limited resources and is anathema to the large majority of physicians.

The competitive model is preferred by officials of the Reagan Administration in part because it would be accompanied by deregulation and dismantling of portions of the Federal bureaucracy. Health-care costs would be restrained by price competition. Individual patients would be required to pay larger portions of their hospital and physicians bills out-of-pocket, either at the time of use or when their insurance premiums exceeded specified levels. They would be motivated to seek lower-priced competitors, and would force their physicians to be conscious -- sometimes painfully conscious -- of the cost of their care. As under rationing, recognition of resource constraints would replace the relatively open-ended subsidies which exist under cost-reimbursement today. The only difference is that rationing would be imposed from the bottom up, by cost-conscious patients, rather than from the top down by politicians. In either case, quality of care could take a back seat to economic constraints.

As an alternative to the rationing and price-competition strategies, PSROs provide some assurance that resources are not wasted. As local physician-directed organizations, they are not oblivious to quality considerations. Their performance can be improved in many ways, including broader physician participation. But are they worse than the alternatives?

It may be that physicians will reminisce about the days when hospital care was ''free'' and the most annoying resource constraints were those communicated by their relatively sympathetic colleagues on behalf of the PSRO. Is it even possible that 1981 will become the good old days? □

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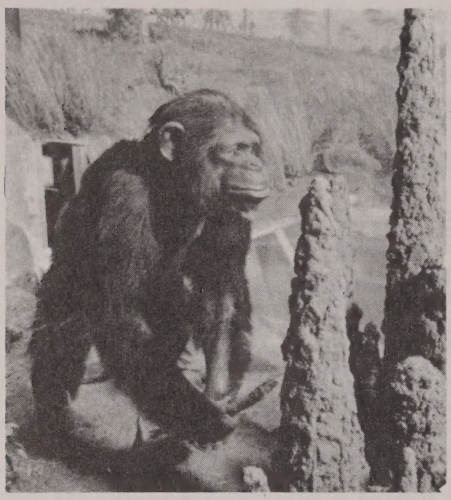

PHELON AFRICAN HALL:

The Science Museum's New Look

The newest exhibit at the Springfield Science Museum, finished last month, includes a ceiling-high diorama of one of Africa's most spectacular sights: Mount Kilimanjaro. At 20,000 feet, it is the continent's highest peak. Grazing elephants, birds in flight, and the sprawling East African countryside at Kilimanjaro's base create a very life-like perspective for the exhibit's three-dimensional foreground. There, a handsome male leopard is mounted at rest, high up on the limb of a tree. Beneath him, a full-grown chimpanzee probes, foraging for food, among the unusual stalagmite towers of a termite nest.

The scene is just one of the twenty-nine permanent exhibits that will be featured in the new R.E. Phelon African Hall, now under construction and slated to open in June of 1981. The most ambitious

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project at the Science Museum in nearly 50 years, the hall has been the priority of Director Glen Ives' agenda since he came to Springfield in the mid-70's. It represents the first major step in a revitalization plan that, assuming funds can be raised, will see the museum redesigned and modernized during the coming years.

The exhibits of Phelon African Hall will be organized around the unifying theme of adaptation and diversity. This in addition to a combined treatment of both the people and wildlife of Africa will make the hall unique among African museum exhibits nation-wide. Built at a cost expected to exceed $500,000, the hall will be the only major exhibit on Africa in New England.

What is more important than the new exhibit's impact on the museum world, however, is the enormous educational potential it holds for the greater Springfield area community.

Exhibits on the traditional culture of people as diverse as the Masai and the Kung! will join varied presentations on contemporary Africa, much of which is as urbanized and industrialized as Europe of America. Wildlife displays emphasizing the great topographical diversity of Africa will include a seven-ton male elephant, a rhinoceros, a lion, many varieties of birds, a pair of warthogs, insects, and several species of antelope. Combined with contemporary art and specially designed audio-visual components, the exhibits in Phelon African Hall will tell the story of Africa, showing how the people and animals of the vast continent adapt to and thrive in their environments.

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Through demonstrations and guided tours the 20,000 or more school children who visit the Science Museum each year will learn principles of ecology and conservation that directly parallel our own environmental predicament. The hall will allow for a continuously changing variety of school programs on subjects ranging from African music and religion to geography and natural history. The store of special programs on Africa will not exclude adults either. No doubt, the hall will have much to say about Africa to people of all ages.

Although the completion of Phelon African Hall is foremost on Director Ives' mind these days, it is not the only project under way at the museum.

Also expected to open late this spring is a refurbished Dinosaur Hall. Accompanying the life-size model of Tyrannosaurus rex will be a cast skeleton of a stegosaurus, some 24 feet in length, two new case displays devoted to the fossil findings of the Connecticut River Valley, a giant graphic time-line, and an audio-visual silo.

A visit to Phelon African Hall and Dinosaur Hall will surprise many visitors. The adjacent halls, which take up much of the oldest part of the building, are dynamic, contemporary, and packed with informative displays. They represent only the beginning of the Science Museum's new look. □

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EXECUTIVE COMMITTEE

The Executive Committee of the Hampden District Medical Society met on Tuesday February 17, 1981 in the Conference Room.

Present were Drs. Siragusa, Walthall, Remsberg, Bagamary, Asinas, Stoddard, Navazio, Ryan, Rich, Mrs. Condon, Dr. Morgan and Mrs. Purdy.

The minutes of the January 6, 1981 meeting were approved as written. They had been mailed out to the committee previously.

CORRESPONDENCE

Dr. Siragusa read the original letter from Ms. Mary Ann Shea, Director of Specialty Services of the Massachusetts Medical Society. This was concerned with Project Good health which had been reviewed by the Tax Supported Medical Care Committee. Further business in this regard will be referred to the Tax Supported Medical Care Committee, as voted by the Executive Committee.

The Executive Committee considered the dues that should be charged for residents and decided on $24.00. This will be referred to the Membership Committee for establishment of a regular dues policy for residents and interns.

Dr. White of Noble Hospital wrote concerning state regulation 243 CMR 2.06 section 14, paragraph A and B which states that a physician

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must explain in detail to the patient who may have breast cancer all available forms of treatment. Dr. White has written Governor King asking for repeal of this law. The Massachusetts Medical Society has been working for this repeal as it was in the beginning trying to stop passage of it. This will be referred to the Massachusetts Medical Society for the latest progress.

OLD BUSINESS

Mrs. Purdy was concerned about the insert in the January issue of the Hampden Hippocrat written by the Area Health Planning Committee. This concern was only for the postage regulations of insertions. However, the committee feels that a similar report written by Dr. Sellei can be printed in the Hampden Hippocrat or sent out in a Newsletter or even the insert which can be mailed to all persons receiving the Hampden Hippocrat.

A letter from Dr. Stagg, Chairman of the Public Health Committee was read to the committee. This was in answer to a letter of complaint from the Heritage Hall Nursing Home about physician's orders for patients. This will be referred to the Massachusetts Medical Society, Dr. Munier, Executive Vice President with a copy of the letter sent to Dr. Hough.

NEW BUSINESS

A letter from Mr. Paul J. Rosenbaum, a radiation physicist was read and explained to the committee. Mr. Rosenbaum wants Hampden District Medical Society to approve his plans to request a license from the State to operate a portable C.T. scanner that could be transported to different hospitals that do not have scanners. The committee felt that more information is needed from Mr. Rosenbaum about this before the committee can approve it. Dr. Siragusa will get in touch with him for more information.

Four requests submitted by Dr. Stoddard were considered by the committee. The requests had to do with Medicaid programs and medical reimbursments. Further information will be acquired in the future through the Tax Supported Medical Care Committee. In answer to questions on letters being answered in a reasonable period of time --- all letters are referred to a committee in a democratic fashion.

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A resolution presented by the Tax Supported Medical Care Committee was considered by the Executive Committee. It was felt that more information was needed and the committee will be so informed.

A bylaw change was presented by the Bylaw Committee's chairman, Dr. James Allan. The Executive Committee discussed this but feel that further explanation is needed. The bylaw changes have been mailed to the membership. Dr. Allan will be asked for revisions.

Further conversation and discussion were held by the committee, regarding merger of the Hampden District Medical Society and Springfield Academy of Medicine. It was felt that Hampden District Medical Society does not have a formal proposal of the merger. A statement was made that the Executive Committee has no problem with the concept of the merger of the Hampden District Medical Society and the Springfield Academy of Medicine. However, the Executive Committee has reservations about the Hampden District Medical Society assuming the financial obligation of the Springfield Academy of Medicine as those obligations are presently structured. The committee agreed that Dr. Fitzpatrick should be notified and Dr. Rich will present questions at the district meeting on March 3, 1981.

The Ambulance report is being considered by the Public Health Committee and no further information is had at this time.

As Dr. John Park is leaving the area, Dr. Siragusa has asked Dr. Boss to take the chairmanship of the Medical Legal Affairs committee for the rest of this year. Dr. Boss has agreed.

Dr. Brendler, Legislative Councilor asked if he could invite legislators to the District Meeting on March 3, 1981. The committee approved of this invitation.

The proposed revision to the bylaws is being deferred to the next executive meeting.

The meeting was adjourned at 10:15 P.M. □

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In Memoriam

EDWARD O. HUBBARD, JR., M.D.

Dr. Edward O. Hubbard, Jr., 65, died on December 31, 1980 after a courageous long and painful bout with Cancer. His illness and death caused much sorrow among those who knew him. His passing is a great loss to the community. He will be remembered always with love by his family, patients, colleagues and friends.

Born in Hancock, N.H., he attended local schools and the University of New Hampshire. He was an all New England Lacrosse player.

He graduated from Tufts Medical School in 1940 and after interning at Newton Hospital entered the Army and served as a Battalion surgeon in the South Pacific where he received the soldier's medal from General Douglas MacArthur for Heroic Service.

Subsequently he was certified by the American Board of Obstetrics and Gynecology in 1951 after residency training in Obstetrics, Gynecology, and Gynecologic pathology at the Boston Lying In Hospital, The Free Hospital for Women (Brookline, MA) The Mary Fletcher Hospital (University of Vermont) and the Providence Lying In Hospital.

After his residency he moved to Springfield and practiced there in Obstetrics and Gynecology until forced to retire because of his illness. He was founding fellow of the American College of Obstetrics and Gynecology and a member of the Obstetrical Society of Boston. He was a capable and caring physician, interested in his work and in people.

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IN MEMORIAM CONTINUED

Dr. Hubbard made many important contributions to the Wesson Women's Hospital. He played a major role in establishing the OB-GYN Residency Program there and served between 1966-70 as Chief of that hospital's medical staff. During that time hospital's intensive care unit for newborns was instituted, the teaching affiliation with the University of Massachusetts Medical School was initiated, Gynecologic services were greatly expanded, Pap Smears became widely used in the hospital's clinics, the use of Rhogam became routine, Electronic Fetal Monitoring was begun and the hospital's first full time chief of OB-GYN was recruited.

He was a conscientious teacher and at the time of his death was an associate clinical professor at Tufts Medical School.

He was a friend and loyal supporter of the nurses with whom he worked.

He was a true New Englander all his life and exemplified the virtues bestowed on New Englanders by writers of Old: uncompromising honesty, industry, dedication to doing right. He had a wonderful "Burt and I" sense of humor.

He loved the Red Sox, hunting, fishing, his dog and his vegetable garden, but he got his greatest enjoyment from helping people. This he did at every opportunity, with enthusiasm, in big ways and in hundreds of thoughful little ways. This is how he will be remembered most of all.

He leaves his beloved wife, Winifred, two sons, Edward O., Kent D. two daughters, Elizabeth J., Martha A. and five grandchildren. □

By Louis C. Clarke, M.D.

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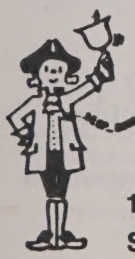

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Almost every year the total of regulative proposals and decrees has increased. This is reflected in the Federal Register, a mere 9,500 pages back in 1950, 61,000 pages in 1978 and 77,000 last year. Projected total this year: 84,000 - and health care regulations constitute a major portion of this total.

One reason is that the Federal Government's share of the health care expense nationwide is approaching 25%.

Another reason comes from the late author Michael J. Halberstam, M.D.: "There's a mindset in the regulatory agencies that suggests physicians are incapable of determining what's best for the patient."

A third (and very current) reason is that regulation is seen as a substitute for various health legislation that Congress spurned.

Here's a partial list of disturbing new rules and proposals from different agencies, mainly the Health Care Financing Administration:

- A directive aimed at cutting off federal funds for hospital construction and renovation in "overbedded" areas. This could lead to nationalizing all health planning.
- A possible rule to limit Medicare payments for certain high-technology items, starting with the CT scanner.
- The idea of barring Medicare payment altogether for various new, emerging, or expensive procedures.

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- A proposal for uniform Annual Hospital Reports as a tool for setting Medicare reimbursement rates, regardless of local and institutional circumstances.

- A proposal for prior review of hospital admissions and elective surgery, etc., under the Medicare program.

- A regulation allowing access to employee medical records.

- A "uniform implementation" rule for Medicare reimbursement of hospital-based physicians.

- A proposal whereby various medical devices would be made available only to certain medical specialties and facilities.

- A proposal for stringent personnel standards for hospital clinical labs.

The AMA is your best defense against the regulatory invasion of your professionalism and practice. An outstanding example: The Food and Drug Administration had proposed patient package inserts (PPIs) for all prescription drugs. Through conferences and written arguments, the AMA narrowed the scope to 10 drugs on a test basis.

We've effectively coped with regulation in a variety of ways, including appeals to the courts. To reform the whole regulatory process, we've offered Congress draft legislation aimed at a larger public voice in the process and greater accountability on the part of the regulators.

To maximize our effectiveness, we need YOUR MEMBERSHIP. The larger our membership, now more than 229,000, the bigger our clout. We need clout in the Congress that sends so much "blank check" legislation to the regulatory agencies. We need Congressional clout in getting regulatory reform. We need clout in dealing with the regulators.

We need YOU...if we're to give you all the help that you need.

For details on how to join, contact your state or county medical society or the AMA Office of Membership Development □

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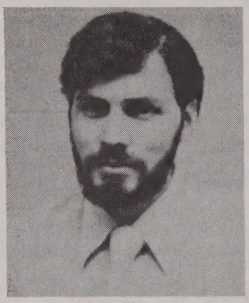
MEDICAL SCHOOL:	University of Vermont College, 1968-72
INTERNSHIP:	John Hopkins Hospital 1972-73
RESIDENCY:	Upstate Medical Center 1973-78 Syracuse, NY
SPECIALTY:	NEUROSURGERY



Lincoln D. Russin, M.D.
Noble Hospital
Westfield, MA 01085

BORN:	October 26, 1944
MEDICAL SCHOOL:	Stanford University School of Medicine 1970
INTERNSHIP:	Santa Clara Valley Medical Center, San Jose, Cal. 1970-71
RESIDENCY:	University of Texas Medical School at San Antonia 1971-73, University of North Carolina 1973-76
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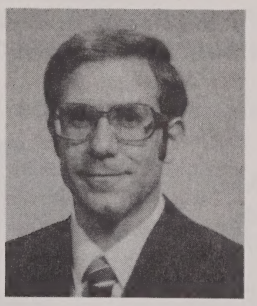
	Jefferson Medical College 1972-74
INTERNSHIP:	Jefferson Hospital 1974-76
RESIDENCY:	Columbia Presbytenan Medical Center 1976-80
SPECIALTY:	ORTHOPEDIC SURGERY



Howard L. Singer, M.D.
759 Chestnut Street
Springfield, MA 01107

BORN:	February 13, 1950
MEDICAL SCHOOL:	Tuft University School of Medicine 1972-76
INTERNSHIP:	Baystate Medical Center, Springfield 1976-77
RESIDENCY:	Baystate Medical Center, Springfield 1977-80
SPECIALTY:	OBSTETRICS/GYNECOLOGY

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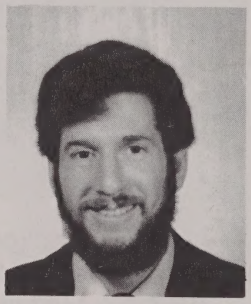
INTERNSHIP:	Hahnemann Medical College & Hospital, Philadelphia 1976-77
RESIDENCY:	Hahnemann Medical College & Hospital, Philadelphia 1977-79
FELLOWSHIP:	In Anesthesiology, George Washington U. Hospital, Washington, D.C. 1979-80
SPECIALTY:	ANESTHESIOLOGY

Stephen J. Levine, M.D.
260 New Ludlow Road
Chicopee, MA 01020



BORN:	June 2, 1947
MEDICAL SCHOOL:	State University of NY at Buffalo School of Medicine 1969-72
INTERNSHIP:	S.U.N.Y. at Buffalo affiliated hospitals 1972-73
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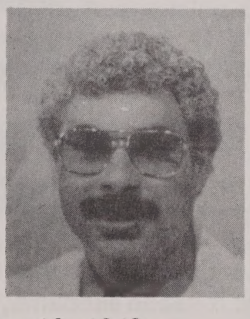
MEDICAL SCHOOL:	S.U.N.Y. at Stony Brook 1968-72
INTERNSHIP:	Dept of Medicine Baystate Medical Center, 1976-77
RESIDENCY:	Dept of Medicine Baystate Medical Center, 1977-79
SPECIALTY:	INTERNAL MEDICINE



Max Chorowski, M.D.
759 Chestnut Street
Springfield, MA 01107

BORN:	November 12, 1949
MEDICAL SCHOOL:	New York Medical College 1971-75
INTERNSHIP:	Rotating Obstetrics & Gyn. Mt. Sinai Hospital, Hartford, CT 1976-79
RESIDENCY:	Mt. Sinai Hospital, Hartford, CT. 1976-79
FELLOWSHIP:	In Liaison Psychiatry, University of Rochester Medical Center 1979-80
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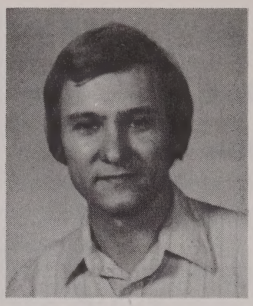
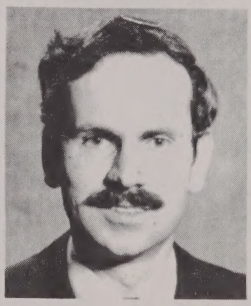


John A. Egelhofer, M.D.
780 Chestnut Street
Springfield, MA 01107

BORN:	January 23, 1953
MEDICAL SCHOOL:	Brown University, 1977
INTERNSHIP:	Baystate Medical Center, 1977-78
RESIDENCY:	Baystate Medical Center, 1978-80
SPECIALTY:	INTERNAL MEDICINE



Joseph F. Burke, M.D.
300 Stafford Street
Springfield, MA 01104

BORN:	April 16, 1946
MEDICAL SCHOOL:	John Hopkins, 1972
INTERNSHIP:	Dartmouth Affiliated Hospitals, Hanover, NH, 1972-73
RESIDENCY:	Dartmouth Affiliated Hospitals Medicine, 1973-75, Boston City Hospital 1975-78, Mass. Eye & Ear Infirmary 1978-80
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LETTER TO THE EDITOR

The Department of Public Welfare is illegally choking money from physicians who provide services to welfare recipients in the Commonwealth of Massachusetts by using random sampling audits of a small number of medical records, and by a "formula" of extrapolation to **each and every claim the doctor had ever submitted.** An astronomical and arbitrary figure is obtained which the Welfare Department demands the physician must pay back to the Commonwealth. Apparently, they are justifying their actions by calling these... "**overpayments**" The statistical validity and the legality of these methods, and especially this "magic formula", have never been challenged and there is an alarming increase in physicians practicing in our Commonwealth and in our District who are now facing this type of bureaucratic harassment. Furthermore, the Welfare Department has **broad-based authority under Massachusetts General Laws to impose** significant sanctions on a physician who refutes this arbitrary and illegal payback. Such sanctions consist of (1) suspension from the Medicaid program, (2) probation for a three-year period, (3) witholding of future payments on outstanding valid claims until the alleged "overpayments" are adjudicated, (4) court action.

Significantly, the **competency** and the **integrity** of the physicians' services are not being questioned by Medicaid. There have been no accusations, directly or by inferences, of any willful wrong-doing. Rather, their complaints focus on the length, volume, or comprehensiveness of the **physician's medical records.** I have no criticism whatever of Big-Government watching carefully where its money is being spent. However, there is a point where government bureaucratic high-handedness has gone too far, and all physicians, organized within their local Medical Society, must take a stand against the Welfare Department's methods. For example, government is wrong to assume us guilty until proven innocent; and government is wrong to impose sanctions and penalties on us without due process.

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It seems to me that the paramount issue should be whether or not the patient has received the highest **quality** of medical care available and not merely the creation of an issue regarding the volume or verbosity of the physician's medical records. Colleagues with whom I have spoken within the Hampden District Medical Society who provide medical services to welfare patients, have openly admitted that they are forced to spend less time with the patient and more time with the patient's medical records in order to comply with the bureaucratic need for quantity rather than quality. Our state government is of the opinion that a "voluminous" medical record substantiates "quality" care. Make no mistake about it, government **is** trying to control medicine. What makes government think they can run medicine more effectively, expeditiously and any cheaper than we physicians can in the private sector? The facts are they have done **nothing** more efficiently and cheaper.

The Department of Medicaid Audits in Fitchburg, Massachusetts should be abolished as a part of President Reagan's new efforts at eliminating waste in government. This trivial branch of Medicaid has done nothing to justify its existence other than harass doctors. Massachusetts wage earners, and physicians in particular, pay more than their share of taxes collected by the Commonwealth to support this needless bureaucratic intrusion into the practice of medicine. Since the Medicaid program was spawned, physicians have been providing services to welfare patients for **vastly substandard or no remuneration whatever.** All of us engaged in hospital practice have been called at any hour of the day or night to attend a sick person who happens to be on General Relief (category "04" welfare); and for these countless hours of effort and service we are not remunerated **one single cent!!!** The work we do **gratis** in our offices as well as in the emergency units, delivery rooms, coronary care units, intensive care units and operating rooms of all the hospitals is the most arduous and most humanitarian and also the **least appreciated by the Welfare bureaucrats.** As physicians, our physical and mental energies, our charity to the poor,

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the donations to our time and services, have long been conveniently and self-servingly ignored by the Massachusetts Department of Public Welfare. It's high time they stopped slashing our fees and paid us a decent wage for a job well done. If we were to challenge the Welfare Department for all these years of **underpayments** and for all these continuing hours of **non-remunerated work,** the Medicaid Department would owe us physicians an abusrd amount of money.

These "gestapo" high-handed procedures and statistically invalid methods used by Medicaid to extract money back from medical providers **must** be challenged. How do we fight back? I would propose that the Hamdpen District Medical Society must stand unified and, as a single voice, start a class action counter suit whenever one of our fellows is frivolously, unjustifiably and inappropriately attacked by the welfare bureaucrats.. We must engage legal counsel. and if necessary a statistical expert, with the single-minded purpose of combatting bureaucratic harassment. This is particularly true considering an individual doctor standing alone would not only find such legal costs prohibitive, but would most certainly lose the battle. If necessary, a threat of en masse resignations of all physicians from the Medicaid Program might be appropriate at a particular date and time in the future. This tactic has worked in other states. We must implore the Massachusetts Medical Society in Boston to stand with us in these efforts. We must be heard. The Hampden District Medical Society must do whatever necessary to defend individual Massachusetts physicians' rights to practice good, competent medicine without undue and unnecessary interference from the State Government. Where one single physician is so attacked, no physician is free - free to practice the quality standards of competency, for a just and fair remuneration, which was the essence of his long, devoted, painstaking, and costly training. □

JOHN J. ALIFANO, JR., M.D.

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Letter To The Editor

AN ACT AUTHORIZING THE CONSENT BY CERTAIN MINORS TO CERTAIN MEDICAL AND DENTAL CARE.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Chapter 112 of the General Laws is hereby amended by striking out section 12F, as amended by section 1 of chapter 335 of the acts of 1971, and inserting in place thereof the following section:-

Section 12F. No physician, dentist or hospital shall be held liable for damages for failure to obtain consent of a parent, legal guardian, or other person having custody or control of a minor child, or of the spouse of a patient, to emergency examination and treatment, including blood transfusions, when delay in treatment will endanger the life, limb, or mental well-being of the patient.

Any minor may give consent to his medical or dental care at the time such care is sought if (i) he is married, widowed, divorced; or (ii) he is the parent of a child, in which case he may also give consent to medical or dental care or tne child; or (iii) he is a member of any of the armed forces; or (iv) she is pregnant or believes herself to be pregnant; or (v) he is living separate and apart from his parent or legal guardian, and is managing his own financial affairs; or (vi) he reasonably believes himself to be suffering from or to have come in contact with any disease defined as dangerous to the public health pursuant to section six of chapter one hundred and eleven; provided, however, that such minor may only consent to care which relates to the diagnosis or treatment of such disease.

Consent shall not be granted under subparagraphs (ii) through (vi), inclusive, for abortion or sterilization.

Consent given under this section shall not be subject to later disaffirmance because of minority. The consent of the parent of legal guardian shall not be required to authorize such care and notwithstanding any other provisions of law, such parent or legal guardian shall not be liable for the payment for any care rendered pursuant to this section unless such parent or legal guardian has expressly agreed to pay for such care.

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No physician or dentist, nor any hospital, clinic or infirmary shall be liable, civilly and criminally, for not obtaining the consent of the parent or legal guardian to render medical or dental care to a minor, if, at the time such care was rendered, such person or facility: (i) relied in good faith upon the representations of such minor that he is legally able to consent to such treatment under this section; or (ii) relied in good faith upon the representations of such minor that he is over eighteen years of age.

All information and records kept in connection with the medical or dental care of a minor who consents thereto in accordance with this section shall be confidential between the minor and the physician or dentist, and shall not be released except upon the written consent of the minor or a proper judicial order. When the physician or dentist attending a minor reasonably believes the condition of said minor to be so serious that his life or limb is endangered, the physician or dentist shall notify the parents, legal guardian or foster parents of said condition and shall inform the minor of said notification. □

JOHN C. AYRES M.D.
Commissioner of Public Health
Springfield

New Arrivals At The Academy Of Medicine

Rutt: A SURGERY OF THE LOWER LEG AND FOOT. Atlas of Orthopedic Surgery v. 2 W.B. Saunders, 1980
PDR Physicians' Desk Reference 1981. 35th ed. Medical Economics
Constantian: M. PRESSURE ULCERS: Principles and Techniques of Management. Little Brown 1980
ACUTE MEDICAL ILLNESS. Medical Clinics of North America v. 65 # 1 January 1981
Egdahl: R et al. MANUAL OF VASCULAR SURGERY. Comprehensive Manuals of Surgical Specialties Springer-Verlag 1980.
ANTI-RHEUMATIC DRUGS II. Clinics in Rheumatic Disease v. 6 # 3 December 1980.
Greenfield: G RADIOLOGY OF BONE DISEASE. J.B. Lippincott 1980.
Hunt: JC.ed. HYPERTENSION UPDATE: Mechanism, Epidemiology, Evaluation, Management.
A CME symposium. Health Learning Systems. 1980.
HAEMATOLOGICAL EFFECTS OF DRUG THERAPY. Clinics in Haematology v. 9 # 3 October 1980.
Paul Dudley White Medical History Society: AESCULAPIAN BOSTON. A guide to places of medical historical interest inthe Hub City and its environs. 1980.
SYMPOSIUM ON THE INFLAMMATORY BOWEL. Medical Clinics of North America November 1980.
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